STATEMENT OF DEFICIENCIES AND PLAN OF C DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	C 10/14/2016

NAME OF PRD VIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
AMELIA NURSING CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

1. Resident # 2 after review of the residents chart, discussion with the resident's daughter meeting with Resident, daughter, ombudsman, administrator and clinical staff it was determined that this facility could not provide the care necessary to safegaurd this resident from elopement. The discharge staff has made efforts to find a facility with a locked unit where this resident would be safe from elopement. A 30 day notice of discharge letter has been sent to the Resident's RP, her daughter. — 11/1/16

2. A 100% audit has been done of all residents charts by the QA nurse and unit managers to review for documentation of elopement as definded by the definition of elopement by National Institute of Elopement Prevention Definition of Elopement- "When a patient or resident who is cognitvely, physcial, mentally, emotionally, and/or chemically impaired wanders away, walks away, runs away, escapes or otherwise leaves a caregiving facility or enviroment unsupervised, unoticed, and/or prior to their discharge." National Institue for Elopement Prevention. — 11/2/16

3. The Abuse Policy and Procedure has been revised to include elopement as a reportable incident and all staff has been educated regarding the new P&P. — 11/2/16

4. The QA Committee will review in the quarterly meeting all facility reported incidents. The Risk Management weekly meeting will also review all Facility Reported Incident and any incidents of elopement. — 11/3/16

LABORATORY DIRECTOR'S OR PRDVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Virginia M Snead — TITLE: Administrator — (X6) OATE: 11-3-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	C 10/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 1	F 225		

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to report three incidents of elopement to the appropriate state agencies for one of six residents in the survey sample, Resident #2.

For Resident #2, facility staff failed to report three incidents of elopement that occurred in May and June of 2016 to the appropriate state agencies.

The findings include:

Resident #2 was admitted to the facility on 3/28/14 with diagnoses that included but were not limited to high blood pressure, high cholesterol, stroke, and Non-Alzheimer's dementia. Resident #2's most recent MDS (minimum data set) was quarterly assessment with an ARD (assessment reference date) of 8/20/16. Resident #2 was coded as being moderately cognitively impaired in the ability to make daily decisions scoring 10 out of 15 on the BIMS (Brief Interview Mental Status) exam. Resident #2 was coded as being independent with most ADL'S (activities of daily living).

Review of Resident #2's clinical record revealed a nursing note dated 5/21/16 that documented in part, the following: "3:35 p.m. - Supervisor noted resident outside with a youth group that was leaving the facility. Resident approached to get her to return back to the facility. 3:30 p.m. supervisor banged on emergency exit door for assistance. Resident noted to be walking around the facility in an attempt to be protesting for her rights and freedom. Resident states that the

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F 225	Continued From page 2	F 225		

facility is violating her human rights because she could not take a picture with the youth group that came in for activities. 4:10 p.m. - Daughter call to assist with getting resident back inside the building. 4:20 p.m., daughter arrived and resident is back in the facility sitting on the couch near the door. Continues to be argumentative with her daughter about being a prisoner here. Daughter making several attempts to reason with her mother at this time."

Further nursing documentation revealed the following: "4:35 p.m., Resident noted outside of facility in parking lot as group was leaving facility. Upon speaking with resident she stated, "She was not returning to facility and was going to walk down the street." Writer advised her that would be unsafe and not in her best interest. Resident said, "that she was going up the hill to the apartments." Again advised resident that was not safe and resident proceeded to ambulate around facility. Resident stated, "that they do this kind of thing all the time in the south. This kind of treatment was unfair to these folks. she was not going to leave this protest at the Dr. King rally." Was able to connect with staff at the south emergency exit. At this time no staff was able to redirect resident back into facility. Numerous attempts made...RP spoke to resident on phone and she too was unable to convince resident to return to facility. Resident proceeded around facility accompanied by x3 staff. Upon returning to entrance, resident continued to refuse to reenter facility. RP arrived and was initially unable to get resident in facility..."

Further review of the clinical record revealed a second occasion where Resident #2 left the building unsupervised. The following was

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F 225	Continued From page 3	F 225		

documented, "5:12 p.m. Resident outside walking around facility by herself without staff presence (sic) at 3:25 p.m. This writer talked to her about same. Pt. (patient) Argumentative and stating "You're not my boss and shut up about this." I just got done with (Name of staff) and (Name of staff) with this same talk and here you come. I'm not in prison, so leave me alone. Explained to her about the unsafeness (sic)..."

The third occasion where Resident #2 left the building was documented on 6/21/16. The following was documented, "4:52 p.m. Resident out wandering in parking lot at this time per DON (Director of Nursing) upon supervisor and UM (unit manager) arriving to front of building resident noted wandering in parking lot near cars with visitor in attempting to back up an no seeing resident and almost hit her. Resident was able to move out of the way in time with no injury noted. CNA (name of CNA) outside on porch sitting with resident in rocking chair at present time as it her desire to stay outside. Staff to continue to monitor resident's safety."

The facility did not submit a FRI (facility reported incident) to the appropriate state agencies regarding the above elopements.

On 10/12/16 at 4:56 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. When asked when a FRI (facility reported incident) would be submitted to the OLC, she stated that an incident should be reported within a 24 hour period and then 5 working days to complete an investigation or provide a follow-up. When asked when the facility would submit a FRI, ASM #1 stated for incidents such as injuries of unknown origin,

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AMELIA NURSING CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

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F 225	Continued From page 4 resident to resident abuse, and staff to resident abuse. When asked if she would submit a FRI to the office if an elopement had occurred, ASM #1 stated yes. When asked what she considered an elopement, ASM #1 stated that she considered an elopement as a resident wandering off the premises. When asked if a FRI should have been submitted for the three occasions that Resident #2 wandered into the parking lot unsupervised, ASM #1 stated, "No she wasn't trying to run away or leave. That'd be different." When asked if Resident #2 had ever threatened to walk down the street or refuse to come into the building, ASM #1 stated, "Yes, but she usually tells staff when she is going outside. Her behavior ended up stopping." ASM #1 stated that once the resident was found outside unsupervised, a staff member would walk with her outside. The DON (Director of Nursing) was out on medical leave and could not be reached for an interview. On 10/14/16 at 1:21 p.m., ASM #1 was made aware of the above concerns. The Facility's Abuse Policy only addressed reporting elopement episodes to the required state agencies only if an injury had also occurred.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	1. Resident #2 after review of the residents chart discussion with the Residents daughter meeting with the residents daughter, ombudsman, adminstrator, and clinical staff it was determined that this facility could not provide the care necessary to safe gaurd the resident from elopement.	11/1/16

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F 226	Continued From page 5	F 226		

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow policies and procedures to report an elopement on three occasions for one of six residents in the survey sample, Resident #2.

For Resident #2, facility staff failed to follow policies and procedures to report an elopement that occurred on three occasions in May and June of 2016.

The findings include:

Resident #2 was admitted to the facility on 3/28/14 with diagnoses that included but were not limited to high blood pressure, high cholesterol, stroke, and Non-Alzheimer's dementia. Resident #2's most recent MDS (minimum data set) was quarterly assessment with an ARD (assessment reference date) of 8/20/16. Resident #2 was coded as being moderately cognitively impaired in the ability to make daily decisions scoring 10 out of 15 on the BIMS (Brief Interview Mental Status) exam. Resident #2 was coded as being independent with most ADL'S (activities of daily living).

Review of Resident #2's clinical record revealed a nursing note dated 5/21/16 that documented in part, the following: "3:35 p.m. - Supervisor noted resident outside with a youth group that was leaving the facility. Resident approached to get her to return back to the facility. 3:30 p.m. supervisor banged on emergency exit door for assistance. Resident noted to be walking around

F 226

2. The QA nurse and unit managers have reviewed the documentation and met with other clinical staff to address any resident who currently could be classified as an elopement risk. 11/2/16

3. The policy and Procedure in place at this time has been revised to include the definition of elopement by the National Institue of Elopement Prevent. This definiation states ""When a patient or resident who is cognitvely, physcial, mentally, emotionally, and/or chemically impaired wanders away, walks away, runs away, escapes or otherwise leaves a caregiving facility or enviroment unsupervised, unoticed, and/or prior to their discharge." As well as noting that elopement is considered a reportable incident. 11/2/16
All staff has been educated on the revised P&P.
In addition a new event tool has been added to the clinical record data base to be completed anytime an elopement occurs. The clinical staff has been educated by the Unit Managers on the use of this tool.

4. All Facility Reported Incidents will be revised at the quarterly QAand also at the weekly Risk Management meetings. 11/3/16

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AMELIA NURSING CENTER	8830 V)RG)N)A STREET AMELIA, VA 23002

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F 226	Continued From page 6	F 226		

the facility in an attempt to be protesting for her rights and freedom. Resident states that the facility is violating her human rights because she could not take a picture with the youth group that came in for activities. 4:10 p.m. - Daughter call to assist with getting resident back inside the building. 4:20 p.m., daughter arrived and resident is back in the facility sitting on the couch near the door. Continues to be argumentative with her daughter about being a prisoner here. Daughter making several attempts to reason with her mother at this time."

Further nursing documentation revealed the fotlowing: "4:35 p.m., Resident noted outside of facility in parking lot as group was leaving facility. Upon speaking with resident she stated, "She was not returning to facility and was going to walk down the street." Writer advised her that would be unsafe and not in her best interest. Resident said, "that she was going up the hill to the apartments." Again advised resident that was not safe and resident proceeded to ambulate around facility. Resident stated, "that they do this kind of thing all the time in the south. This kind of treatment was unfair to these folks. she was not going to leave this protest at the Dr. King rally." Was able to connect with staff at the south emergency exit. At this time no staff was able to redirect resident back into facility. Numerous attempts made...RP spoke to resident on phone and she too was unable to convince resident to return to facility. Resident proceeded around facility accompanied by x3 staff. Upon returning to entrance, resident continued to refuse to reenter facility. RP arrived and was initially unable to get resident in facility..."

Further review of the clinical record revealed a

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F 226	Continued From page 7	F 226		

second occasion where Resident #2 left the building unsupervised on 6/4/16. The following was documented, "5:12 p.m. Resident outside walking around facility by herself without staff presence (sic) at 3:25 p.m. This writer talked to her about same. Pt. (patient) Argumentative and stating "You're not my boss and shut up about this." I just got done with (Name of staff) and (Name of staff) with this same talk and here you come. I'm not in prison, so leave me alone. Explained to her about the unsafeness (sic)..."

The third occasion where Resident #2 left the building was documented on 6/21/16. The following was documented, "4:52 p.m. Resident out wandering in parking lot at this time per DON (Director of Nursing) upon supervisor and UM (unit manager) arriving to front of building resident noted wandering in parking lot near cars with visitor in attempting to back up an no seeing resident and almost hit her. Resident was able to move out of the way in time with no injury noted. CNA (name of CNA) outside on porch sitting with resident in rocking chair at present time as it her desire to stay outside. Staff to continue to monitor resident's safety."

The facility did not submit a FRI (facility reported incident) to the appropriate state agencies regarding the above elopements.

On 10/12/16 at 4:56 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. When asked when a FRI (facility reported incident) would be submitted to the OLC, she stated that an incident should be reported within a 24 hour period and then 5 working days to complete an investigation or provide a follow-up. When asked when the

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F 226	Continued From page 8 facility would submit a FRI, ASM #1 stated for incidents such as injuries of unknown origin, resident to resident abuse, and staff to resident abuse. When asked if she would submit a FRI to the office if an elopement had occurred, ASM #1 stated yes. When asked what she considered an elopement, ASM #1 stated that she considered an elopement as a resident wandering off the premises. When asked if a FRI should have been submitted for the three occasions that Resident #2 wandered into the parking lot unsupervised, ASM #1 stated, "No she wasn't trying to run away or leave. That'd be different." When asked if Resident #2 had ever threatened to walk down the street or refuse to come into the building, ASM #1 stated, "Yes, but she usually tells staff when she is going outside. Her behavior ended up stopping." ASM #1 stated that once the resident was found outside unsupervised, a staff member would walk with her outside. The DON (Director of Nursing) was out on medical leave and could not be reached for an interview. On 10/14/16 at 1:21 p.m., ASM #1 was made aware of the above concerns. The Facility's Abuse Policy only addressed reporting elopement episodes to the required state agencies only if an injury had also occurred.	F 226		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280	1. Resident #2's care plan has been updated to include the attempts resident has made to elope and measures to be used to help prevent elopement. The resident and resident's daughter have been invited to participate in the care planning process.	10/24/16

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F 280	Continued From page 9 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined that facility staff failed to review and revise the comprehensive care plan for one of six residents in the survey sample; Resident #2. For Resident #2, facility staff failed to update the comprehensive care plan after each elopement episode and document new interventions to be implemented to prevent further elopements. The findings include: Resident #2 was admitted to the facility on 3/28/14 with diagnoses that included but were not limited to high blood pressure, high cholesterol, stroke, and Non-Alzheimer's dementia. Resident #2's most recent MDS (minimum data set) was	F 280	2. The 100% audit of residents documentation for any resident who may be a possible elopement risk also included care plan review of anyone who posed an elopement risk. 3. The clinical staff has been educated on the elopement event tool that is part of the clinical data base. This is to be completed for any elopement. Part of this tool triggers immediate interventions used and the need for care plan updates. 4. The MDS Coordinator will review care plan updates in the weekly Risk Management meeting and at the quarterly QA meeting for all Facility Reported Incident.	11/2/16 11/2/16 11/3/16

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F 280	Continued From page 10	F 280		

quarterly assessment with an ARD (assessment reference date) of 8/20/16. Resident #2 was coded as being moderately cognitively impaired in the ability to make daily decisions scoring 10 out of 15 on the BIMS (Brief Interview Mental Status) exam. Resident #2 was coded as being independent with most ADL'S (activities of daily living).

Review of Resident #2's clinical record revealed a nursing note dated 5/21/16 that documented in part, the following: "3:35 p.m. - Supervisor noted resident outside with a youth group that was leaving the facility. Resident approached to get her to return back to the facility. 3:30 p.m. supervisor banged on emergency exit door for assistance. Resident noted to be walking around the facility in an attempt to be protesting for her rights and freedom. Resident states that the facility is violating her human rights because she could not take a picture with the youth group that came in for activities. 4:10 p.m. - Daughter call to assist with getting resident back inside the building. 4:20 p.m., daughter arrived and resident is back in the facility sitting on the couch near the door. Continues to be argumentative with her daughter about being a prisoner here. Daughter making several attempts to reason with her mother at this time."

Further nursing documentation revealed the following nursing note dated 5/21/16: "4:35 p.m., Resident noted outside of facility in parking lot as group was leaving facility. Upon speaking with resident she stated, "She was not returning to facility and was going to walk down the street." Writer advised her that would be unsafe and not in her best interest. Resident said, "that (Sic.) she was going up the hill to the apartments."

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Again advised resident that was not safe and resident precede (Sic.) to ambulate around facility. Resident stated, "that they do this kind of thing all the time in the south. This kind of treatment was unfair to these folks. she (Sic.) was not going to leave this protest at the Dr. King rally." Was able to connect with staff at the south emergency exit. At this time no staff was able to redirect resident back into facility. Numerous attempts made...RP spoke to resident on phone and she too was unable to convince resident to return to facility. Resident proceeded around facility accompanied by x3 staff. Upon returning to entrance, resident continued to refuse to reenter facility. RP arrived and was initially unable to get resident in facility..."

Further review of the clinical record revealed a second occasion on 6/4/16 where Resident #2 left the building unsupervised. The following was documented, "5:12 p.m. Resident outside walking around facility by herself without staff presence (sic) at 3:25 p.m. This writer talked to her about same. Pt. (patient) Argumentative and stating "You're not my boss and shut up about this." I just got done with (Name of staff) and (Name of staff) with this same talk and here you come. I'm not in prison, so leave me alone. Explained to her about the unsafeness (sic)..."

The third occasion where Resident #2 left the building was documented on 6/21/16. The following was documented, "4:52 p.m. Resident out wandering in parking lot at this time per DON (Director of Nursing) upon supervisor and UM (unit manager) arriving to front of building resident noted wandering in parking lot near cars with visitor in attempting to back up and not seeing resident and almost hit her. Resident was

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able to move out of the way in time with no injury noted. CNA (name of CNA) outside on porch sitting with resident in rocking chair at present time as it her desire to stay outside. Staff to continue to monitor resident's safety."

Review of Resident #2's care plan dated 8/22/16 did not address her elopement episodes or any new interventions in place to prevent elopement. The following was documented under care area Cognitive Loss/Dementia: "Resident A (alert) and Oriented 2-3 with some impairment. Moves freely around the building-knows how to locate places, can get short tempered; family involved, increased confusion during evening hours; pacing up and down hallway...Goal: Will voice satisfaction with care given. Approach (Interventions): Avoid assuming an overly protective attitude, Calm resident if signs of distress develops during the decision making process, encourage resident to verbalize feelings and fears, encourage small group programs, Limit/structure resident choices...provide cues and supervision, provide special environmental stimuli, set expectations and limits for resident..."

On 10/12/16 at 5:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked about the purpose of a care plan, LPN #3 stated that it was used to direct the care for each individual resident. LPN #3 stated that it was updated with any new changes such as skin problems, mental status, falls etc. When asked where a resident elopement would be documented, she stated that an elopement should be documented in a nursing note and on the care plan. LPN #3 stated that any staff member providing direct care can refer back to the care plan and should be able to find

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information about an elopement if it had occurred.

On 10/14/16 at 11:00 a.m., an interview was conducted with LPN #4. When asked about the purpose of a plan was, LPN #4 stated that it was to address alt aspects of care for each resident. When asked when the care plan is updated, LPN #4 stated that it was updated with any changes such as mental or physical. When asked who updates the care plan, LPN #4 stated that MDS updates the care plan. She stated that nurses will tell MDS of any new changes that occurred with the resident and then MDS will update the care plan. When asked if incidents such as elopements would be on the care plan, LPN #4 stated, "I would consider elopements something that should be on the care plan because new interventions should be in place like alarms." When asked if she could find where Resident #2's episodes of elopements are documented on the care plan, LPN #4 stated that she could not find evidence of elopements.

On 10/14/16 at 11:13 p.m., an interview was conducted with LPN #6, the MDS coordinator. LPN #6 was asked the purpose of a care plan. LPN #6 stated that the care plan was to give facility staff a basic idea of what the resident can or can't do. When asked when the care plan is updated, LPN #6 stated that it is updated every day with new doctor orders, significant changes, and quarterly. When asked if elopement episodes should be on the care plan, LPN #6 stated, yes. LPN #6 stated that she had never known for Resident #2 to elope. LPN#6 stated, "I wouldn't say that she elopes. She knows her whereabouts, that's why it is not on the care plan. She likes to walk around."

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F 280	Continued From page 14 On 10/14/16 at 1:21 p.m., ASM #1, the administrator was made aware of the above findings. No further information was presented prior to exit. Facility policy titled, "Wandering Resident" documents in part the following: "The safety and wellbeing of all residents with potential for wandering is ensured at all times. POLICY: All residents who are at risk for harm because of wandering behavior have Resident Care Plan that addresses the issue..." Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	1. Resident #2 has refused all staff efforts to provide safety measures. She agreed to the placement of a wander guard transponder then removed it after 2 days. Refused to allow it to be placed back on her person. All attempts by staff and her daughter to reason with Resident #2 have failed.	11/3/16

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review it was determined that facility staff failed to implement safety measures to prevent elopement for one of six residents in the survey sample, Resident #2.

For Resident #2, facility staff failed to implement interventions and safety measures after two incidents of elopement.

The findings include:

Resident #2 was admitted to the facility on 3/28/14 with diagnoses that included but were not limited to high blood pressure, high cholesterol, stroke, and Non-Alzheimer's dementia.

Resident #2's most recent MDS (minimum data set) was quarterly assessment with an ARD (assessment reference date) of 8/20/16. Resident #2 was coded as being moderately cognitively impaired in the ability to make daily decisions scoring 10 out of 15 on the BIMS (Brief Interview Mental Status) exam. Resident #2 was coded as being independent with most ADL'S (activities of daily living).

Review of Resident #2's clinical record revealed a nursing note dated 5/21/16 that documented in part, the following: "3:35 p.m. - Supervisor noted resident outside with a youth group that was leaving the facility. Resident approached to get her to return back to the facility. 3:30 p.m.

Cont. She states "I know my rights" All facility staff are aware of this residents failure to comply with safety measures. Staff will provide continuous monitoring of her where abouts until her discharge. A monitoring flowsheet has been set up to document this intervention. No chemical interventions have been used. Unit Manager to check daily.

2. A 100% audit of all chart documentation by the QA nurse and unit managers to assure all safety measures were in place if needed by all residents. 11/2/16

3. All staff has been educated by QA how to provide a safe environment for the residents and appropriate safety measures have been reviewed with all clinical staff. 11/2/16

4. All Facility Reported Incidents and Incident/Accident reports are reviewed weekly by the Risk Management committee and quarterly by the QA committee for appropriate interventions to provide a safe environment. 11/3/16

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supervisor banged on emergency exit door for assistance. Resident noted to be walking around the facility in an attempt to be protesting for her rights and freedom. Resident states that the facility is violating her human rights because she could not take a picture with the youth group that came in for activities. 4:10 p.m. - Daughter call to (Sic.) assist with getting resident back inside the building. 4:20 p.m., daughter arrived and resident is back in the facility sitting on the couch near the door. Continues to be argumentative with her daughter about being a prisoner here. Daughter making several attempts to reason with her mother at this time."

Further nursing documentation revealed the following: "4:35 p.m., Resident noted outside of facility in parking lot as group was leaving facility. Upon speaking with resident she stated, "She was not returning to facility and was going to walk down the street." Writer advised her that would be unsafe and not in her best interest. Resident said, "that (Sic.) she was going up the hill to the apartments." Again advised resident that was not safe and resident proceeded to ambulate around facility (Sic.). Resident stated, "that (Sic.) they do this kind of thing all the time in the south. This kind of treatment was unfair to these folks. she (Sic.) was not going to leave this protest at the Dr. King rally." Was able to connect with staff at the south emergency exit. At this time no staff was able to redirect resident back into facility. Numerous attempts made...RP (responsible party) spoke to resident on phone and she too was unable to convince resident to return to facility. Resident proceeded around facility accompanied by x3 (three) staff. Upon returning to entrance, resident continued to refuse to reenter facility. RP (responsible party) arrived

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and was initially unable to get resident in facility..."

Review of Resident #2's clinical record revealed that on 5/23/16, the physician had written an order for (1) Risperdal 0.25 mg (milligrams) 1 tablet daily. The same day the order for Risperdal was discontinued.

The following note was documented on 5/23/16 at 5:07 p.m.,"3-11 Notified RP via telephone of new order for Risperdal 0.25 mg at which time RP stated, "I'm not sure I want her on a brand new medication. I really have to think about this." Educated RP on medication's drug classification at which RP stated understanding, but still questioned origin of order. RP stated, "I don't want her on any new medications and I would lie (Sic.) MD (medical doctor) to talk to me before placing her on any new medications." MD (medical doctor) was notified via telephone of conversation and gave new order to DC (discontinue) aforementioned order. RP notified of d/c (discontinue) of new order via telephone and thanked writer for update. Staff will continue to monitor for duration of shift."

On 5/24/16 the following order was written: "Consult Psych."

Further review of the clinical record revealed a second occasion on 6/4/16 where Resident #2 left the building unsupervised. The following was documented, "5:12 p.m. Resident outside walking around facility by herself without staff presence (Sic.) at 3:25 p.m. This writer talked to her about same. Pt. (patient) argumentative and stating "You're not my boss and shut up about this." I just got done with (Name of staff) and (Name of staff) with this same talk and here you come. I'm

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not in prison, so leave me alone. Explained to her about the unsafeness (Sic.)..."

On 6/16/16 at 2:31 p.m., the following nursing note was documented: "Writer spoke with RP at this time regarding that resident is going to need to have a psych (psychiatric) apt (appointment) scheduled for outside of facility d/t (due to) resident's increased behaviors and decreased safety awareness. Explained to RP that resident is a danger to herself D/T (due to) the decreased safety awareness and that on 6/15/16 resident was wandering the parking lot on 3-11 shift and that staff was outside with her but were worried for her safety with the amount of cars and ambulances that come and go from facility that may not be aware that there may be a resident wandering the parking lot...Spoke with RP also regarding that possibility that this psy (Sic.) MD (Medical Doctor) could place resident on an antipsychotic medication. RP agreeable to possible medications at this time."

The third occasion where Resident #2 left the building was documented on 6/21/16. The following was documented, "4:52 p.m. Resident out wandering in parking lot at this time per DON (Director of Nursing) upon supervisor and UM (unit manager) arriving to front of building resident noted wandering in parking lot near cars with visitor in attempting to back up an (Sic.) no (Sic.) seeing resident and almost hit her. Resident was able to move out of the way in time with no injury noted. CNA (name of CNA [certified nursing assistant]) outside on porch sitting with resident in rocking chair at present time as it her desire to stay outside. Staff to continue to monitor resident's safety."

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The following note dated 6/28/16 at 4:06 p.m. documented in part, the following: "Resident's daughter in to talk with DON (Director of Nursing) and writer regarding her mother stating she just doesn't know what to do with her. RP informed staff that resident unhappy that the clinical social worker came to talk to her last night saying that this person was very evasive per RP. Writer advised RP that this lady that her mother had spoken with last night was only a counselor and that she could not order medications or make recommendations. Writer notified RP that the person coming in around the middle of the month to see her mother from (Name of Organization) would be someone who could either write medication orders or make recommendations to (Name of house MD). RP asked the lady who saw her mother last night not see her again as it upset her mother...RP further discussed that she wanted her mother to be happy and writer and DON discussed with her while we want her very much to be happy that our main priority was her safety. DON explained that we have had signs up out front advising visitors and staff to slow down in the parking lot as to hopefully alert others to the safety of the residents. RP agreed. RP discussed trying to find her mother another facility with a locked unit in order to keep her safe and hopefully make her happy...administrator came in and joined the discussion and encouraged RP to visit another facility in (name of town) where they have this type of unit. RP stated that she would. RP also stated that a senior services Rep (Representative) would be in tomorrow with RP to talk with her mother and administrator stated that this would be a great idea and that she would like to meet this person while she was in the facility..."

No further documentation could be found

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regarding the senior services representative's visit or if the visit took place. No documentation could be found regarding the clinical social worker's visit.

On 7/15/16 the following note was documented: " 1:09 p.m., Per (Sic.) administrator's request psych apt (appointment) canceled and no further apt to be made after receiving multiple phone calls and messages from resident's daughter regarding psych apt and her concerns of her mother having to see the psychiatrist. MD and transportation made aware of administrator's decision. Writer phoned rp/daughter (Sic.) and made her aware that psych apt was canceled. Per administrator d/t (due to) her concerns that no further apt was to be made..."

Review of the clinical record failed to reveal any further interventions attempted to maintain Resident #2's safety. The facility staff could not provide evidence that safety checks were put into place. Review of the clinical record failed to reveal any wandering/elopement risk assessment and assessment for the use of a wander guard for Resident #2. There was no further evidence that the facility was following up with better placement for Resident #2 with a locked unit. Review of Resident #2's care plan dated 8/22/16 did not address her elopement episodes or any new interventions in place to prevent elopement. On 10/12/16 at 4:15 p.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated that the first episode occurred because the NAACP came into the facility to visit with the residents. She stated that this triggered a flashback with Resident #2 who thought she was back in the 60's participating in the Dr. King Marches. She stated that after that episode,

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there were a few other episodes where Resident #2 exited the building. When asked what was done to prevent Resident #2 from wandering out into the parking lot, ASM #1 stated that the doctor had tried to order antipsychotic medications and a psychology consult, but the daughter had refused the medications and numerous attempts for psychological services to assess Resident #2. She stated that psychological services was involved at one point, but was not sure what happened with that. ASM #1 stated, "(Name of Resident) may have kicked the social worker out but I am not sure. I have to check on that."

On 10/12/16 at 4:30 p.m., an interview was conducted with LPN (Registered Nurse) #1, the unit manager. LPN #1 stated that Resident #2's daughter did not want many things. She stated that the daughter would agree to the medication and psychological services and then she would change her mind and have the doctor discontinue these interventions. When asked what was put into place if the medications and psychological consults were refused to keep Resident #2 safe and prevent further elopement, LPN #1 stated that everyone watches her and keeps her safe. When asked how the resident got out of the building and in the parking lot if everyone is supposed to be watching her, LPN #1 stated that they have had several meetings with the daughter and now the daughter herself is obtaining psychological services. LPN #1 stated that hopefully after the daughter obtains services, it will convince her to let her mother obtain services.

On 10/12/16 at 4:56 p.m., further interview was conducted with ASM #1. When asked if Resident #2 had ever threatened to walk down the street or

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refuse to come into the building, ASM #1 stated, "Yes, but she usually tells staff when she is going outside. Her behavior ended up stopping." ASM #1 stated that once the resident was found outside unsupervised, a staff member would walk with her outside. When asked if the facility had a wander guard system, ASM #1 stated, "yes." When asked if this was an intervention attempted for Resident #2, ASM #1 stated that it hasn't been attempted for quite some time. ASM #1 stated, "She has been here awhile. I think she may have cut it off awhile back." This writer asked if ASM #1 could provide documentation of a wander guard attempt for Resident #2. ASM #1 stated, "Back in July and June (2016) I felt that she (Resident #2) was not happy here. I felt like she would have been happier and safer somewhere else." ASM #1 stated that she had also looked for a different facility for Resident #2 that had a locked unit. ASM #1 stated, "I think the daughter visited the facility I recommended, but the distance was too far for her." When asked if there were any other attempts to place the resident in another facility, ASM #1 stated that her behavior had stopped so she was no longer considered unsafe.

On 10/12/16 at 5:58 p.m., an interview was conducted with OSM (Other staff member) #3, the clinical social worker. OSM #3 stated that she had visited Resident #2 at some point in May or June for psychotherapy. She stated that she talked briefly with Resident #2 who did not appear to be in any distress, and appeared to be "calm and cool." OSM #3 stated that she was scheduled to have a meeting with Resident #2 the following day, but was notified that the daughter and resident did not want OSM #3 to be speaking with Resident #2. OSM #3 stated that

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she wasn't sure the reasoning behind this decision. When asked if she had documented the initial visit, OSM #3 stated that she was new at the time and does not think that she had documented the visit.

ASM #1 could not provide evidence that a wander guard was attempted for safety. Evidence of a monitoring system or safety check system could not be provided.

On 1/21/16 at 1:21 p.m., another interview was conducted with ASM #1, regarding the process followed for applying a wander guard to a resident. ASM #1 stated that it was nursing judgment upon admission. When asked if a resident is ever re-assessed for the use of a wander guard, ASM #1 stated, "Yes and they (residents) get very angry when they go off because some of them just want to sit in the lobby." ASM #1 was made aware of the above concerns.

Facility policy titled, "Wandering Resident" documents in part the following: "The safety and wellbeing of all residents with potential for wandering is ensured at all times. POLICY: All residents who are at risk for harm because of wandering behavior have Resident Care Plan that addresses the issue...If a resident repeatedly wanders off the unit, the Resident Care Plan should reflect a monitoring schedule to ensure resident safety. The monitoring schedule is determined according to the resident's wandering patterns..."

(1) Risperdal-Used to treat schizophrenia, bipolar disorder, or irritability by autistic disorder. This

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F 323	Continued From page 24 medicine should not be used to treat behavioral problems in older adults who have dementia. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012012/?report=details.	F 323		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain a complete and accurate clinical record for one of 6 resident in the survey sample, Resident #2. For Resident #2, facility staff failed to document a psychological evaluation from the clinical social worker after she had three episodes of elopement. The findings include:	F 514	1. Documentation not there because Resident #2 would not talk to LCSW. She was new to facility and was just trying to introduce herself to people. LCSW was spoken to by Adminstrator regarding lack of documentation and from now on even if resident refuses to be seen she must document the attempt and turn into us so we can scan into chart. 11/4/16 2. 100% audit by QA nurse and Unit Manager of all those residents listed to be seen for Pschological services to assure all documentation is in the chart. 11/3/16 3. In-service with unit managers and Social Services by QA to make sure proper communication form isused by all psychological consultants. 11/3/16 4.Unit Manager to report on all those incidents using psychological services at the weekly Risk Management. Social Services to report to QA meeting quarterly regarding those residents requiring any pschological services for that quarter. 11/3/16	

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Resident #2 was admitted to the facility on 3/28/14 with diagnoses that included but were not limited to high blood pressure, high cholesterol, stroke, and Non-Alzheimer's dementia. Resident #2's most recent MDS (minimum data set) was quarterly assessment with an ARD (assessment reference date) of 8/20/16. Resident #2 was coded as being moderately cognitively impaired in the ability to make daily decisions scoring 10 out of 15 on the BIMS (Brief Interview Mental Status) exam. Resident #2 was coded as being independent with most ADL'S (activities of daily living).

Review of Resident #2's clinical record revealed a nursing note dated 5/21/16 that documented in part, the following: "3:35 p.m. - Supervisor noted resident outside with a youth group that was leaving the facility. Resident approached to get her to return back to the facility. 3:30 p.m. supervisor banged on emergency exit door for assistance. Resident noted to be walking around the facility in an attempt to be protesting for her rights and freedom. Resident states that the facility is violating her human rights because she could not take a picture with the youth group that came in for activities. 4:10 p.m. - Daughter call to assist with getting resident back inside the building. 4:20 p.m., daughter arrived and resident is back in the facility sitting on the couch near the door. Continues to be argumentative with her daughter about being a prisoner here. Daughter making several attempts to reason with her mother at this time."

Further nursing documentation revealed the following: "4:35 p.m., Resident noted outside of facility in parking lot as group was leaving facility.

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Upon speaking with resident she stated, "She was not returning to facility and was going to walk down the street." Writer advised her that would be unsafe and not in her best interest. Resident said, "that she was going up the hill to the apartments." Again advised resident that was not safe and resident proceeded to ambulate around facility. Resident stated, "that they do this kind of thing all the time in the south. This kind of treatment was unfair to these folks. she (sic.) was not going to leave this protest at the Dr. King rally." Was able to connect with staff at the south emergency exit. At this time no staff was able to redirect resident back into facility. Numerous attempts made...RP (responsible party) spoke to resident on phone and she too was unable to convince resident to return to facility. Resident proceeded around facility accompanied by x3 staff. Upon returning to entrance, resident continued to refuse to reenter facility. RP arrived and was initially unable to get resident in facility..."

Review of Resident #2's clinical record revealed that on 5/23/16, the physician had written an order for (1)Risperdal 0.25 mg (milligrams) 1 tablet daily. The same day the order for Risperdal was discontinued.

The following note was documented on 5/23/16 at 5:07 p.m.,"3-11 Notified RP via telephone of new order for Risperdal 0.25 mg at which time RP stated, "I'm not sure I want her on a brand new medication. I really have to think about this." Educated RP on medication's drug classification at which RP stated understanding, but still questioned origin of order. RP stated, "I don't want her on any new medications and I would lie (sic,) MD (medical doctor) to talk to me before placing her on any new medications." MD was

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notified via telephone of conversation and gave new order to DC (discontinue) aforementioned order. RP notified of d/c of new order via telephone and thanked writer for update. Staff will continue to monitor for duration of shift."

On 5/24/16 the following order was written: "Consult Psych (psychiatrist)."

Further review of the clinical record revealed a second occasion on 6/4/16 where Resident #2 left the building unsupervised. The following was documented, "5:12 p.m. Resident outside walking around facility by herself without staff presence (sic) at 3:25 p.m. This writer talked to her about same. Pt. (patient) Argumentative and stating "You're not my boss and shut up about this." I just got done with (Name of staff) and (Name of staff) with this same talk and here you come. I'm not in prison, so leave me alone. Explained to her about the unsafeness..."

On 6/16/16 at 2:31 p.m., the following nursing note was documented: "Writer spoke with RP at this time regarding that resident is going to need to have a psych apt (appointment) scheduled for outside of facility d/t (due to) resident's increased behaviors and decreased safety awareness. Explained to RP that resident is a danger to herself D/T the decreased safety awareness and that on 6/15/16 resident was wandering the parking lot on 3-11 shift and that staff was outside with her but were worried for her safety with the amount of and ambulances that come and go from facility that may not be aware that there may be a resident wandering the parking lot...Spoke with RP also regarding that possibility that this psy MD (medical doctor) could place resident on an antipsychotic medication. RP agreeable to

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possible medications at this time."

The third occasion where Resident #2 left the building was documented on 6/21/16. The following was documented, "4:52 p.m. Resident out wandering in parking lot at this time per DON (Director of Nursing) upon supervisor and UM (unit manager) arriving to front of building resident noted wandering in parking lot near cars with visitor in attempting to back up an no seeing resident and almost hit her. Resident was able to move out of the way in time with no injury noted. CNA (name of CNA [certified nursing assistant]) outside on porch sitting with resident in rocking chair at present time as it her desire to stay outside. Staff to continue to monitor resident's safety."

The following note dated 6/28/16 at 4:06 p.m. documented in part, the following: "Resident's daughter in to talk with DON and writer regarding her mother stating she just doesn't know what to do with her. RP informed staff that resident unhappy that the clinical social worker came to talk to her last night saying that this person was very evasive per RP. Writer advised RP that this lady that her mother had spoken with last night was only a counselor and that she could not order medications or make recommendations. Writer notified RP that the person coming in around the middle of the month to see her mother from (Name of Organization) would be someone who could either write medication orders or make recommendations to (Name of house MD). RP asked the lady who saw her mother last night not see her again as it upset her mother...RP further discussed that she wanted her mother to be happy and writer and DON discussed with her while we want her very much to be happy that our

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main priority was her safety. DON explained that we have had signs up out front advising visitors and staff to slow down in the parking lot as to hopefully alert others to the safety of the residents. RP agreed. RP discussed trying to find her mother another facility with a locked unit in order to keep her safe and hopefully make her happy...administrator came in and joined the discussion and encouraged RP to visit another facility in (name of town) where they have this type of unit. RP stated that she would. RP also stated that a senior services Rep would be in tomorrow with RP to talk with her mother and administrator stated that this would be a great idea and that she would like to meet this person while she was in the facility..."

No documentation could be found regarding the clinical social worker's visit for evaluation.

On 10/12/16 at 5:58 p.m., an interview was conducted with OSM (Other staff member) #3, the clinical social worker. OSM #3 stated that she had visited Resident #2 at some point in May or June for psychotherapy. She stated that she talked briefly with Resident #2 who did not appear to be in any distress, and appeared to be "calm and cool." OSM #3 stated that she was scheduled to have a meeting with Resident #2 the following day, but was notified that the daughter and resident did not want OSM #3 to be speaking with Resident #2. OSM #3 stated that she wasn't sure the reasoning behind this decision. When asked if she had documented the initial visit, OSM #3 stated that she was new at the time and does not think that she had documented the visit.

On 10/21/16 at 1:21 p.m., ASM (administrative

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F 514	Continued From page 30 staff member) #1, the administrator was made aware of the above findings. No further information was provided prior to exit. The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." (1) Risperdal-Used to treat schizophrenia, bipolar disorder, or irritability by autistic disorder. This medicine should not be used to treat behavioral problems in older adults who have dementia. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012012/?report=details.	F 514		